VISIT PREPARATION CHECKLIST

Southeastern Dermatology Consultants
Matthew B. Doppelt, D.O.

Name:____ Date: ____/____/________

Today's visit is for:____
If we have time, I'd also like to discuss:____

In addition to medical and surgical dermatology services, ***The Medical Spa at Southeastern Dermatology Consultants*** *is available to individuals who desire state of the art aesthetic enhancement. Botox, Restylane, Photofacial, Permanent hair reduction, Spa Facials, and home therapy products are but a few of our offerings.*
❑ I am interested in learning about procedures, products, and services that are designed to improve my appearance.
❑ I am interested in a consultation with the Practice's Licensed Aesthetician.

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS

- ❑ ***Skin Cancer:***
  - Melanoma; Date:__________
    Location___________________________
  - Squamous Cell Carcinoma
  - Basal Cell Carcinoma
  - Actinic Keratosis (pre-skin cancer)
  - Other:_____________________________
- ❑ ***Dermatological Disease:***
  - Psoriasis
  - Eczema
  - Acne / Rosacea
  - Blistering Disorder:___________________
  - Healing problems; slow, keloid, bruising
  - Other:_____________________________
- ❑ ***Immunological Disease:***
  - Immune Deficiency
  - HIV / AIDS
  - Lupus or Scleroderma
- ❑ ***Hematology / Oncology:***
  - Cancer; type:_________________________
  - Bleeding Problems
- ❑ ***Rheumatological Disease:***
  - Osteoarthritis
  - Rheumatoid Arthritis
  - Gout
- ❑ ***Psychological / Emotional Disease:***
  - Depression
  - Obsessive – Compulsive
- ❑ ***Gastrointestinal Disease***:
  - Crohn's Disease, Ulcerative Colitis
  - Esophageal Reflux
  - Peptic ulcer
  - Esophagitis
- ❑ ***Cardiovascular Disease:***
  - High Blood Pressure
  - Heart Problems: ________________________
  - Heart Attack; Date:____________________
  - Pacemaker / AICD
  - Irregular heartbeat
  - High Cholesterol
- ❑ ***Endocrine Disease:***
  - Diabetes
  - Hyperthyroid / Hypothyroid
- ❑ ***Neurological Disease:***
  - Stroke / Aneurysm
  - Seizure / Epilepsy
  - Alzheimer's
  - Fainting
- ❑ ***Liver Disease:***
  - Hepatitis; type:____________
  - Jaundice
- ❑ ***Lung Disease:***
  - Asthma
  - COPD
  - Tuberculosis
- ❑ ***Kidney Disease:***
  - Poorly functioning kidneys
  - Dialysis; type___________________________
- ❑ ***For Female Patients:***
  - Are you pregnant / Planning Pregnancy
  - Polycystic ovarian disease
- ❑ ***Other / Not Listed:***
  - ______________________________
  - ______________________________
  - ______________________________
  - ______________________________

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:

SURGERIES

TYPE OF SURGERY	SURGEON	HOSPITAL	DATE

HOSPITALIZATIONS (DO NOT INCLUDE SURGERIES LISTED ABOVE)

REASON	DOCTOR	HOSPITAL	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions/Problems	*Family Members affected and exact nature of problems*
❑ Melanoma	
❑ Cancer	
❑ Blistering Disorder	
❑ Auto-Immune Disorder	
❑ Psoriasis	

SOCIAL HISTORY / HABITS

- ❑ Occupation____________________________ ❑ Retired
- ❑ Smoker: _____ packs/day ❑ Non-smoker ❑ Quit smoking in ______
- ❑ Smokeless Tobacco:____________________________
- ❑ Alcohol use: ❑ Yes (drinks/week:_____________) ❑ No
- ❑ Recreational Drug use: ❑ No ❑ Yes _____________________________
- ❑ Sunscreen use: ❑ Regularly ❑ Rarely ❑ Never
- ❑ I have traveled outside the United States in the past three months:___________

TANNING / SUN EXPOSURE

Do you / Have you had
- ❑ Always burn, never tan
- ❑ Usually burn, tan w/ difficulty
- ❑ Sometimes burn, usually tan
- ❑ Rarely burn, tan easily

❑ At least 1 blistering sunburn
❑ Utilize a tanning bed

REVIEW OF SYSTEMS: Please mark the symptoms you've been having recently.

GENERAL
- ❑ weight gain / loss
- ❑ loss of appetite
- ❑ fever / chills
- ❑ weakness
- ❑ night sweats

SKIN
- ❑ rash
- ❑ lumps
- ❑ dry/sensitive skin
- ❑ hives
- ❑ suspicious moles
- ❑ suspicious lesions
- ❑ jaundice
- ❑ acne
- ❑ itching
- ❑ hair loss

EAR/NOSE/THROAT
- ❑ congestion
- ❑ nosebleed
- ❑ change in voice
- ❑ sore throat
- ❑ difficulty swallowing

ALLERGY
- ❑ runny nose
- ❑ scratchy throat
- ❑ itchy eyes
- ❑ sinus congestion
- ❑ sneezing

CARDIOLOGY
- ❑ chest pain
- ❑ palpitations
- ❑ leg swelling

MUSCULOSKELETAL
- ❑ joint stiffness
- ❑ leg cramps
- ❑ joint pain
- ❑ joint swelling
- ❑ back pain
- ❑ neck pain
- ❑ muscle aches

RESPIRATORY
- ❑ shortness of breath
- ❑ chest tightness
- ❑ cough
- ❑ wheezing
- ❑ congestion

PSYCHOLOGY
- ❑ depression
- ❑ high stress level
- ❑ suicidal thinking
- ❑ eating disorder
- ❑ mental or physical abuse
- ❑ mood swings
- ❑ obsessive - compulsive tendencies

ENDOCRINE
- ❑ excessive sweating
- ❑ excessive thirst
- ❑ excessive urination
- ❑ heat intolerance
- ❑ cold intolerance

BLOOD/LYMPH
- ❑ swollen glands
- ❑ fatigue
- ❑ varicose veins
- ❑ easy bruising

EYES
- ❑ decreased vision
- ❑ eye irritation
- ❑ eye drainage
- ❑ blurry vision

NEUROLOGY
- ❑ headache
- ❑ tingling/numbness
- ❑ seizures
- ❑ dizziness

GASTROENTEROLOGY
- ❑ nausea
- ❑ vomiting
- ❑ heartburn
- ❑ abdominal pain
- ❑ change in bowel habits

UROLOGY
- ❑ difficulty urinating
- ❑ blood in urine
- ❑ leaking urine

____
Patient Signature *Date*

____
Physician Signature *Date*

Updated: 2008-11-18